STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN47150

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F0000	This visit was for a post survey visit (PSR) to the Recertification and State Licensure Survey completed on June 17, 2011. This visit was in conjunction with the investigation of Complaint IN00093499. Survey dates: August 9 and 10, 2011 Facility number : 001145 Provider number: 155616 Aim number : 200120200 Survey team: Gloria J. Reisert, MSW/TC Dorothy Navetta RN Avona Connell RN Donna Groan RN , Census bed type: SNF/NF: 61 Residential: 24 Total: 85 Census payor type: Medicare: 08 Medicaid: 43 Other: 34 Total: 85	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 9 Supplemental: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/14/11 Cathy Emswiller RN			

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F0225 SS=E	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review, observation and interview the facility failed to report a residents exiting the facility within 5 days and thoroughly investigated, who had a wanderguard, and sustained an abrasion to	F0225	F225 I. Resident #26 was assessed by a licensed nurse with no sign or symptoms of injury. The Interdisciplinary Team reviewed the Resident and updated the Care Plan. Resident	08/18/2011

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	the forehead for 1 of 1 resident reviewed with a wanderguard in a supplemental sample of 8. (Resident #26) Findings include: On 8/9/11 at 1:20 p.m., in interview with LPN #1, she indicated a resident got out on the property. The door was not working for the wander guard. Maintenance checked the door, it didn't work. A new wanderguard bracelet was applied. It didn't work at the door. It wouldn't sound. All you had to do was push the door open. We were told to watch the door. The clinical record for Resident #26 was reviewed on 8/10/11 at 6:40 a.m. The resident's diagnoses included, but were not limited to Parkinson,s disease and dementia. The most recent MDS (Minimum Data Set) quarterly assessment dated 7/18/11 indicated the resident was severely cognitively impaired. Nurse's Notes included, but were not limited to: 7/30/11 5:30 pm "Alerted by visitor that Resident fell and needed help getting up. Resident found sitting on ground by swing back of facility. Abrasion noted to forehead. residents vitals and neuro's noted. assisted in wc (wheelchair) and taken to NSG (nursing)		#26 is being monitored and has had no episodes of attempting to and/or leaving facility unattended. II. All residents were reviewed for unreported unusual occurrences. No unreported unusual occurrences were identified. III. The facility's Unusual Occurrence Reporting policy was revised and approved by QA. All facility staff will receive directed inservice training on Unusual Occurrence Policy. The Administrator will report all unusual occurrences to Corporate Nurse and ISDH. IV. A copy of the unusual occurrence report and validation of submission to ISDH will be maintained by the Administrator. The Corporate Nurse will review all reports and validation. The Administrator will report to QA weekly for four weeks, monthly for 3 months and then quarterly. V. COMPLETION DATE: August 18, 2011	

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	station. On call MD, Supervisor, Maint (maintenance), and ADM (Administrator) called. Door blocked to keep anyone using til checked by maint. Will continue to monitor and notify family..." An Incident Accident Report form provided by the Administrator for review on 8/9/11 at 2:15 p.m. included, but was not limited to: 7/30/11 5:20 p.m., Res exited through back door of facility wanderguard did not sound back door not latching. Witness b y visitor. Visitor tried to assist res. to sit in swing to go seek help et (and) res. slid off the swing while trying to sit." On 8/9/11 at 1:05 p.m., in interview with the Maintenance Director, he wasn't aware the other maintenance worker had come in. Accompanied by the Maintenance Director, the distance from the back door (near the beauty shop) to the swing was measured as 78 feet. He was not aware of a work order being made out for the door. Documentation was lacking of the state agency being notified within 5 days of the incident and thoroughly investigated. 3.1-28(d)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician orders were followed for laboratory values to be drawn. (Resident # 65) This affected 1 of 1 resident reviewed for labs in a supplemental sample of 7. Findings include:	F0282	F282I. Resident #65 no longer resides in this facility. II. All residents will be reviewed outstanding lab orders. III. A Lab Tracking Calendar will be initiated to identify lab orders and appropriate follow through including but not limited to lab draw. Licensed nurses will receive a directed inservice on facility's expectation that all labs ordered will be drawn as ordered. IV. The DON or designee will review new orders daily to identify lab orders. The DON or designee will maintain Lab Tracking Calendar to assure appropriate follow through including but not limited to lab draws as ordered. The DON will report to QA weekly for four weeks, monthly for 3 months and then quarterly. V. COMPLETION DATE: August 18, 2011	08/18/2011

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	On 8/10/2011 at 7:45 a.m., record review indicated Resident # 65 had diagnoses of, but not limited to: dementia, congestive heart failure, and acute renal failure. Review of the clinical record indicated a lack of documentation that a basic metabolic panel (BMP) and a complete blood count (CBC) had been done according to a physician order written on 6/29/2011 upon returning from hospital. Physician order written on 6/29/2011 indicated to have a BMP and CBC drawn on Monday - 7/4/2011. The physician re-ordered labs to be drawn on 7/6/2011 in a.m. On 7/7/2011 at 6:00 p.m., upon receiving lab values and notifying the physician, nursing notes indicate that he wanted intravenous (IV) fluids started. Nursing notes indicate that they could not start the IV. The physician then ordered Resident # 65 to be sent to hospital. On 8/9/2011 at 1:30 p.m., in interview with Licensed Practical Nurse (LPN) # 1, she indicated that the labs had been overlooked. 3.1-35(g)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F0323	F323 I. Resident #26 was assessed by a licensed nurse with no sign or symptoms of injury. The Interdisciplinary Team reviewed the Resident and updated the Care Plan. Resident #26 is being monitored and has had no episodes of attempting to and/or leaving facility unattended. II. All residents were reviewed for unreported unusual occurrences. No unreported unusual occurrences were identified. III. The facility's Wanderguard System Validation Policy was revised to reflect checking the Wanderguard SYstem of all doors on all shifts, weekly, and as needed. The Policy Revision was reviewed and approved by QA. All facility staff will receive directed inservice training on Wanderguard System Validation Policy and escaltion of concerns with Wanderguard System functioning. IV. A copy of the Wanderguard System Validation Records and concerns with Wanderguard System functioning will be escalated to the Maintenance Department with records kept. The Corporate Nurse will review all reports and validation. The Administrator will report to QA weekly for four weeks, monthly for 3 months and	08/18/2011

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	Based on record review, observation and interview the facility failed to ensure the wanderguard system was working properly to prevent a resident from exiting the building through a door which malfunctioned, who had a wanderguard in place and sustained an abrasion to the forehead for 1 of 1 resident reviewed with a wanderguard in a supplemental sample of 8. (Resident #26) Findings include: On 8/9/11 at 1:20 p.m., in interview with LPN #1, she indicated a resident got out on the property. The door was not working for the wander guard. Maintenance checked the door, it didn't work. A new wanderguard bracelet was applied. It didn't work at the door. It wouldn't sound. All you had to do was push the door open. We were told to watch the door. The clinical record for Resident #26 was reviewed on 8/10/11 at 6:40 a.m. The resident's diagnoses included, but were not limited to Parkinson,s disease and dementia. The most recent MDS (Minimum Data Set) quarterly assessment dated 7/18/11 indicated the resident was severely cognitively impaired.		then quarterly. V. COMPLETION DATE: August 18, 2011	

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Nurse's Notes included, but were not limited to: 7/30/11 5:30 pm "Alerted by visitor that Resident fell and needed help getting up. Resident found sitting on ground by swing back of facility. Abrasion noted to forehead. residents vitals and neuro's noted. assisted in wc (wheelchair) and taken to NSG (nursing) station. On call MD, Supervisor, Maint (maintenance), and ADM (Administrator) called. Door blocked to keep anyone using til checked by maint. Will continue to monitor and notify family..."

An Incident Accident Report form provided by the Administrator for review on 8/9/11 at 2:15 p.m. included, but was not limited to: 7/30/11 5:20 p.m., Res exited through back door of facility wanderguard did not sound back door not latching. Witness b y visitor. Visitor tried to assist res. to sit in swing to go seek help et (and) res. slid off the swing while trying to sit."

On 8/9/11 at 1:05 p.m., in interview with the Maintenance Director, he wasn't aware the other maintenance worker had come in. Accompanied by the Maintenance Director, the distance from the back door (near the beauty shop) to the swing was measured as 78 feet.

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	On 8/10/11 at 11:50 a.m., the Administrator provided the manufacturers instructions Testing the Wanderguard E series door module(s). The WARNING included, but was not limited to: "Test the Wanderguard departure alert system regularly. Do not rely exclusively on Wanderguard E built-in self-tests to indicate the Wanderguard E system is working properly. Test door modules weekly on each shift with all surrounding power devices turned on. Record the results... " On 8/10/11 at 9:05 a.m., the Maintenance Director provided a Daily Preventative maintenance Record for the Wanderguards. July 30 was indicated, but lacked which shift as did all of the dates listed. The facility failed to check the door modules per the manufacturers instructions. 3.1-45(a)(2)			
R0000	THE FOLLOWING STATE RESIDENTIAL DEFICIENCIES WERE CITED IN ACCORDANCE WITH 410	R0000		

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	IAC 16.2-5.			

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview the facility failed to report an unusual occurence of a resident being arrested for a DUI (Driving Under the Influence) while residing at the facility for 1 of 1 closed record review for discharge in a sample of 6. (RR6) Findings include: During interview on 8/9/11 at 9:30 a.m., LPN #1 indicated an AL (assisted living) resident was drunk in the parking lot, hit sign, called a nurse a racial slur, blew a .9 on the breathalizer and was arrested. He wrecked employee cars. He was "drunker than drunk" last week on August 3." The clinical record for Residential Resident #6 was reviewed on 8/10/11 at 7:45 a.m. The resident was admitted to the facility on 7/1/11. The resident's diagnoses included, but were not limited to insulin dependent diabetes mellitus and ETOH (alcohol) abuse. Nurse's Notes included, but were not limited to: 7/16/11 "Res (resident) found outside doors to back parking lot door pt (patient) stated he fell attempting to come into facility. Pt	R0090	R0090I. RR6 no longer resides in facility. II. All residents were reviewed for unreported unusual occurrences. No unreported unusual occurrences were identified. III. The facility's Unusual Occurrence Reporting policy was revised and approved by QA. All facility staff will receive directed inservice training on Unusual Occurrence Policy. The Administrator will report all unusual occurrences to Corporate Nurse and ISDH. IV. A copy of the unusual occurrence report and validation of submission to ISDH will be maintained by the Administrator. The Corporate Nurse will review all reports and validation. The Administrator will report to QA weekly for four weeks, monthly for 3 months and then quarterly. V. COMPLETION DATE: August 18, 2011	08/18/2011

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	has scraps (sic) to R (right) knuckle R outer knee and R hip area. Res stated he did not hit head Speech slurred pt smells of ETOH. Pt is slightly disoriented. Pt stated that he had several drinks today. pt admitted to drinking and driving scraps (sic) cleaned res. assisted to bed...Late Entry Res passed out sleeping quietly in bed..." "8/1/11 8:30 PM Resident parking truck in parking lot run truck into handicapped spot cursed at CNA (certified nursing assistant) [named] using racial remarks threatened CNA that he would beat him up. Admistrator notified and to take care of incident. 9:30 pm Resident stopped in w/c (wheelchair) on, residential nursing desk left hand nicked up and bleeding slightly stated he beat up the wooden gate in the court yard, refused first aide. DON notified and requested Resident to be placed on 15 minute checks. Resident speech slurred, smelled of whiskey. DON aware Adminstrator aware." "8/3/11 10:15 p.m. Resident left facility @ 4 pm after recieiving (sic) 30 U (units) Novol 70/30 stated he was going out to eat supper with a friend. Around 8:30 pm as I was leaving for my lunch CNA [named] told me that Resident was sitting outside in parking lot of [name of facility] in his truck aalseep (sic) with windown			

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	(sic) partially open with his truck running I went and woke him up and asked him if he would come inside as it was too hot to sit inside a running truck he said "so what" and went back to sleep. I called [named] DON and asked her if I could have permission to call Police to have him arrested for DWI (sic) before he killed hisself or somebody. She informed me to call the Admistrator [named] for permission of which I did. [Named] gave me permission to call Police while I was talking with police Resident hit my car, CNA [named] car and the side unit air conditioner of the building, and left parking lot. The New Albany Police Dept. arrived and Resident pulled in Parking lot at same time parked his truck as he hit " In interview with the Administrator on 8/10/11 at 9 a.m., she indicated she did not report this incident as an unusual occurence because no services were disrupted, when the telephone pole was hit."			
R0408	(c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview the facility failed to ensure newly admitted	R0408	R0408I. Chest x-rays were taken and were negative for TB signs/symptoms for Residents #1,	08/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents had documentation a chest x-ray was completed at the time of admission or 6 months prior for 3 of 5 newly admitted residents' records reviewed in a residential sample of 6 residents. (Resident #1, #3, #5.) Findings include: The following Residential residents lacked a chest x-ray completed on admission or 6 months prior to admission. Review of the clinical record on 8/9/2011 at 10:30 a.m. indicated Resident #1was admitted on 07/28/11. Review of the clinical record on 8/9/2011 at 11:00 a.m. indicated Resident #3 was admitted on 07/28/11. Review of the clinical record on 8/9/2011 at 10:22 a.m., Resident #5 was admitted on 07/28/11. In interview with the Administrator at 1:30 p.m., on 08/09/11, she indicated she did not have information related to chest x-rays for the above residents. She further indicated she would contact the previous nursing facility and try to obtain information.		#3 and #5. II. All residential residents were reviewed for the presence of chest x-ray. Those residents without chest x-ray results within 6 months prior to admission had a chest x-ray completed to rule out the presence of TB. III. Infection Control Policies and Procedures were reviewed by QA and found to be appropriate. Licensed nurses and Community Liason Director will receive directed in-service regarding Infection Control policies; including but not limited to expectation that chest x-ray is completed within 6 months prior to new admission. IV. DON or designee will review preadmission information to assure chest x-ray has been completed and results are available prior to admission. DON or designee will report to QA weekly for four weeks, monthly for 3 months and quarterly thereafter. V. COMPLETION DATE: August 18, 2011	